HEALTHY CONNECTIONS VALUE CARE (HCVC)
FREQUENTLY ASKED QUESTIONS (DEC. 2019)

What is the Healthy Connections Value Care (HCVC) program?	Healthy Connections Value (HCVC) Care is the next phase of the Healthy Connections Program. It is a Value-Based Incentive Payment Program with a year-end settlement based on financial and quality performance. This optional program builds on the current Healthy Connections reimbursement structure of fee for service payments and Healthy Connections PMPM Case Management fee payments by allowing participating organizations to choose to be "at-risk" to share in savings and contribute to offsetting increased costs.
Why is Idaho Medicaid implementing the HCVC Program?	Like many other state Medicaid programs and commercial plans, Idaho faces unsustainable health care cost growth. • Idaho Medicaid spending grew 7% from state fiscal year 2018 (7/2017 – 6/2018) to state fiscal year 2019 (7/2018 – 6/2019). • Over the same period, the average number of Medicaid eligible individuals decreased by 11,000 participants or 4%. • The total cost for the Medicaid program in state fiscal year 2020 will exceed $2.8 billion. With the increasing cost of healthcare, an aging population, and a voter-approved ballot initiative for Medicaid expansion, Idaho has an immediate need for reform to control costs without reducing the quality of care or restricting the access to care. Idaho Medicaid believes that continuing to build on the patient-centered approach present in our Healthy Connections program, with a focus on reducing non-emergency visits to the Emergency Department, reducing avoidable hospitalizations and readmissions, and focusing on clinical coordination and prevention, will help accomplish this goal.
What is the effective date of the HCVC Program?	Effective date is July 1, 2020 with the program expected to run for three years, through June 30, 2023.
Will the new HCVC Program result in changes in the overall Medicaid Program?	Current Medicaid program remains in place including health benefits, prior-authorization and referral process, Healthy Connections member enrollment process and Healthy Connections tier levels and Case Management payments. Current physician and hospital fee schedules all remain unchanged.
What is a VCO?	A Value Care Organization (VCO) is any HCSL, network of HCSLs or Physician Hospital network that includes HCSLs who have executed an Agreement with the Department to participate in the HCVC Program.

Who is eligible to participate?	Any Healthy Connections Service Location (HCSL) with an active Healthy Connections Coordinated Care Provider agreement is eligible to voluntarily participate in a Value Care Organization (VCO) as part of an: • Accountable Primary Care Organizations (APCO): Designed for HC Primary Care Providers or organizations that serve a minimum of 1,000 HC members and contract with the Department to participate in the value and risk-based reimbursement model. • Accountable Hospital Care Organizations (AHCO): Designed for integrated network of providers, that includes an acute care hospital, that serve a minimum of 10,000 HC members and contract with the Department to participate in the value and risk-based reimbursement model.
How can a HCSL participate?	• HCSLs can participate individually as an Accountable Primary Care Organization (APCO) provided they meet the minimum requirement of 1,000 assigned Healthy Connections Participants and they can perform the duties of an APCO as outlined in the HCVC Agreement. • HCSLs with less than the minimum requirement of Assigned Healthy Connection Participants can network together to form an APCO to meet the requirements of the HCVC Agreement. • Any HCSL can participate in the HCVC Program by participating through a Clinically Integrated Health Network that has executed an Accountable Hospital Care Organization (AHCO) Agreement with Healthy Connections.
Can a HCSL participate in more than on network?	No. Participation in the Idaho Medicaid HCVC Program is exclusive and HCSLs may only participate in one AHCO or APCO.
What is the advantage to contract with a AHCO?	Most Physician Hospital networks contracting with the department as an AHCO have administrative resources to assume the duties assigned to the AHCO under the HCVC Agreement. There may be other advantages or disadvantages depending on your specific situation and the AHCO with which you are considering contracting. We encourage you to talk to them directly.
Is participation in the HCVC Program mandatory?	Participation in the HCVC Program is voluntary and Healthy Connections Organizations can opt to not participate and remain enrolled as a Healthy Connections Provider.
What is the term of the Agreement and is there a penalty if I don't join the first year?	The term of the HCVC Program is for three years and begins on July 1, 2020. HCSLs that choose not to participate in year one may still participate in years two and/or three, but they will enter into the contract based on the terms and conditions set forth in the Agreement for the year(s) in which they participate.
I am interested in exploring my options under the HCVC program. How do I obtain data to ensure I	HCVC Program materials can be found on the Healthy Connections website at www.healthyconnections.idaho.gov For HC Providers interested in participating in the HCVC Program, historical cost and quality data can be requested by e-mailing Healthy Connections Value Care at MedicaidValueCare@dhw.idaho.gov

make the right choice for my organization?	
How is the Total Cost of Care formula calculated?	The TCOC formula is calculated on a Per Member Per Month (PMPM) basis which is the total Actual Cost of care adjusted for Stop Loss cases divided by the total Member Months of Participants Attributed to the VCO. The TCOC formula is calculated as follows *Step 1: Base Year Actual Cost PMPM / Base Year Ave. Risk Score = Risk Standardized PMPM* *Step 2: Risk Standardized PMPM * Inflation Trend* Performance Year Ave. Risk Score = Performance Year Gross Target PMPM* *Step 3:* Performance Year Gross Target PMPM – Performance Year Actual Cost PMPM = VCO TCOC Savings or Loss
How is the VCO's share of VCO TCOC Savings or Losses determined?	Prior to the start of each Performance Year, the VCO will select the level of risk sharing it is willing to accept for the year from the options below. The risk options are slightly different for APCOs vs AHCOs. The level of risk sharing selected each year must be equal to or greater than the level of risk of the previous year. Option 1 (APCO) – Symmetrical Savings and Loss Risk Sharing • Minimum Risk Share (Savings or Loss) Year 1 – 10% • Minimum Risk Share (Savings or Loss) Year 2 – 15% • Minimum Risk Share (Savings or Loss) Year 3 – 25% • Maximum Risk Share each year – 80% Option 1 (AHCO) – Symmetrical Savings and Loss Risk Sharing • Minimum Risk Share (Savings or Loss) Year 1 – 10% • Minimum Risk Share (Savings or Loss) Year 2 – 25% • Minimum Risk Share (Savings or Loss) Year 3 – 50% • Maximum Risk Share each year – 80% Option 2 (APCO and AHCO) – Asymmetrical Savings and Loss Risk Sharing • Share of Savings or Loss may be different (Asymmetrical) as described below • Year 1 Risk Share 40% of Savings and 20% of Loss • Year 2 Risk Share 40% Savings and 20% Loss or Option 1 Year 2 terms • Year 3 Mandatory Option 1 Year 3 terms The VCO's share of the VCO TCOC Savings or Loss is calculated as described below:

	*Step 4: VCO TCOC Savings or Loss * VCO Risk Share % of Savings or Loss = VCO Share of VCO Savings or Loss*
Is there a savings or loss minimum threshold?	Yes, the Performance-Year Savings/Loss must exceed a minimum (TBD.05 – 1.0%) of the Gross Target to trigger VCO's savings or loss.
How is the Year-End Settlement determined?	In the event of Shared Savings, the VCO share of VCO Savings will be split equally into two pools for determining distribution, a Quality Pool and an Efficiency Pool. *Step 5: VCO Share of Savings /2 = Efficiency Pool Funds Eligible for Distribution* *: VCO Share of Savings/2 = Quality Pool Funds Eligible for Distribution* The Efficiency Pool Funds will be distributed in total provided the VCO maintains a minimum level of quality standards. If the minimum standards are not met, there will be no distribution of funds from the Efficiency Pool. The Quality Pool Funds will be eligible for distribution based on the VCO's performance improvement in the Quality measures and according to the quality measurement formulas. Following the measurement of the VCO's quality performance, the final Efficiency Pool and Quality Pool funds to be distributed will be combined and then compared to the Payout Limit of 50% of the VCO's Healthy Connections Management fee for the year for APCOs or 15% of the VCO's Gross Target PMPM for AHCOs. The Department will pay to the VCO the lesser of the two amounts. In the event of Shared Losses, the VCO share of VCO Losses will be compared to the loss limit of 50% of the VCO's Healthy Connections Management fee for the year for APCOs and 15% of the VCO's Gross Target PMPM for AHCOs. The VCO will pay the Department the lesser of the two amounts. *Step 6: Final Quality Pool Fund + Final Efficiency Pool Funds = Total Funds to Distribute* *: Payout to VCO the lesser of the Total Funds to Distribute or Payout Limit* *or* *: Payment by VCO the lesser of VCO share of Loss or Loss Limit*
What Medicaid services are included in the TCOC formula?	Diagnostic services (lab tests, imaging, etc.) Durable medical equipment Emergency medical transport Hospice Care

	Home Health Services Inpatient Hospital services Outpatient Hospital services Inpatient behavioral health Outpatient facilities including ambulatory surgery Professional (primary care, specialty care, physical therapy, speech therapy, etc.)
What Medicaid services are excluded from the TCOC formula?	Behavioral health services administered through a managed-care contract Dental services administered through a managed-care contract Home and Community-Based Waiver Services (e.g. services provided to participants in their home or community rather than institutions, such as personal care services or meals) Long-term Supports & Services Non-emergent medical transportation services administered through a managed-care contract Nursing Home or Intermediate Care Facilities Pharmacy Skilled Nursing
What is the HCVC attribution process?	For purposes of calculating the VCO's annual TCOC, Participants will be attributed to the VCO when they were assigned to one of the VCO's Healthy Connections Service Locations for at least seven months during the Base Year and Performance Year. For participants attributed to a VCO, the VCO will be responsible for the Total Cost of Care for the entire period the participant is enrolled in the Healthy Connections Program. <u>Example: 12 months of Healthy Connections Program eligibility</u> - 7 months Assigned to VCO 1 - 5 months Assigned to VCO 2 Participant would be Attributed to VCO 1 for the entire 12-month period and all claims would be Attributed to VCO 1 and included in the TCOC calculation.
What are the Payout Limit and Loss limit?	It is the maximum amount that a VCO could receive in Savings distribution from the Program and the maximum amount that a VCO could have to pay the Department in the event of a Loss. The maximum Savings or Loss for an APCO: 50% of VCO's Healthy Connections Management Fee for the Year. The maximum Savings or Loss for an AHCO: 15% of the VCO's TCOC Gross Target PMPM.
What is the Stop Loss provision?	The Stop Loss provision helps to mitigate the financial impact of certain high-cost Participants in determining Actual Cost in both the Base Year and each Performance Year. The Stop Loss threshold amount is $100,000 annual aggregate per Participant. There will be a copayment, or inclusion in Actual Cost, of 20% for costs between $100,000 and $500,000. For example, if the annual aggregate costs for a

	Participant is $200,000, only $120,000 of those costs will be included in the VCO's Actual Cost amount. Costs over $500,000 are excluded entirely from the Actual Cost and the Total Cost of Care calculations.
What Risk Scoring methodology will be utilized?	The Milliman MARA CXAdjuster Risk Scoring methodology will be utilized to adjust Base Year Actual Cost for Attributed Participant health risk in setting the Gross Target PMPM.
What Inflation Trend Factor will be utilized in comparing costs from Base year to Performance Year?	The Milliman Medical Index (MMI), as published in approximately July of each year, will be applied to the Base Year PMPM to trend costs forward in setting the Gross Target PMPM for each Performance Year. The Trend Factor for each Performance Year will not exceed an increase or decrease of 1.0% from the previous year index. For example, if the index used to develop the prior year Gross Target PMPM was 4.0% and the index for the current year is 5.3%, the index used to calculate the current year Gross Target PMPM would be 5.0%, the lesser of 5.3% and 5.0% (4.0% + 1.0%). Conversely, if the index used in the prior year was 4.0% and the current year index is 2.7%, the index used in the current year would be 3.0%, the greater of 2.7% and 3.0% (4.0% - 1.0%)
What impact will quality measures have on paying out shared savings?	VCO's Share of Savings will be divided equally into Quality and Efficiency Pools for potential distribution: • One half could be earned through an **"efficiency pool"** of dollars which rewards lowering costs as long quality of care is maintained. • The other half can be earned through a "**quality pool**" of dollars which rewards performance in meeting incremental quality improvement targets.
How will the Quality Pool payment be calculated?	Payments to the VCO from the quality pool will be established based on their performance in meeting quality measure improvement targets or statewide goal. Targets will be re-evaluated based on the prior year performance (baseline).
How is the statewide quality measure goal determined?	State and national goals will be identified for each measure as available. These benchmarks will be set at the 90th percentile for the state or nationally, whichever is higher.
What is the Individualized Annual Improvement Target?	Each organization begins the program with their established baseline based upon State Fiscal year 2019. To meet a measure, an organization will need to reduce the gap between its baseline and the benchmark by 10 percent (or demonstrate at least a 3% minimum improvement (floor) as they near the benchmark). Improvement targets encourage continued, incremental year-over-year improvement toward the statewide goal over time.
Where can I find a listing of Healthy	Please visit the Healthy Connections website at www.healthyconnections.idaho.gov for a list of all HCVC measures as well as the specific details of each measure.

Connections Value Measures?	
How do I know which measures apply to my clinic?	All qualifying measure are included in an organization's measurement. To be considered a "qualifying measure," the VCO shall have a minimum of 30 participants included in the measure denominator.
Will organizations be able to provide supplemental data to validate scores?	This is not an option at this time. The use of claims-based quality measures is designed to lessen impact on providers and continued evaluation of these measures will occur as the program evolves.
In launching the HCVC program, DHW will establish two advisory groups in each region. What are they and what are their roles?	**Regional Care Collaborative (RCC).** A RCC will be established by the Department as a way for the Department and the VCOs in the region to monitor and evaluate the performance of the Program in meeting its goals and objectives. The RCC will also provide a forum for raising concerns and recommending solutions regarding issues that may arise in the delivery of healthcare to Participants in the region. **Community Health Outcome Improvement Coalition (CHOICe).** The Department shall identify or establish a Community Health Outcome Improvement Coalition (CHOICe) for each region. The CHOICe will help identify opportunities to improve health and wellness, create health equity and address the social determinants of health in their communities, among other activities.
I see the Department has issued a Request For Information (RFI) on Value-Based Purchasing (VBP). How is the HCVC program impacted by the RFI?	The HCVC Program is an innovative VBP model that Idaho has been developing with stakeholders over the past several years. It will provide an opportunity for Healthy Connections Providers and others to voluntarily move to a value-based approach beginning in 2020. In addition to the HCVC program, Idaho Medicaid recognizes the importance of stakeholder engagement as we identify, build, and test additional models for VBP. To meet this goal, Idaho is seeking input from a wide variety of stakeholders and partners familiar with the health care delivery system in Idaho including individuals who use Medicaid services, health care providers, health insurance providers, advocates, vendors and potential vendors, policy makers, and other interested parties. You may learn more about this request and providing input by January 3, 2020 at the IDHW website: healthandwelfare.idaho.gov.
I still have questions. Who do I call?	If you have any questions you can email Healthy Connections Value Care at MedicaidValueCare@dhw.idaho.gov or by phone 1-888-528-5861 and someone will be able to assist you.